



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION

**CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)**

**IDENTIFYING INFORMATION**

CHILD'S NAME	BIRTHDATE
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**CURRENT STATE OF HEALTH**

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on \_\_\_\_ / \_\_\_\_ / \_\_\_\_, this child can participate in a child care program. This child has no special care needs unless specified below.

*(Date of medical examination must be within the last 12 months.)*

**PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE**

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

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SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE
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PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER



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**CHILD ENROLLMENT**

CHILD'S NAME	SEX	BIRTH DATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		HOME TELEPHONE NUMBER ( )

<b>OPTIONAL</b>	<b>SCHOOL CHILD ATTENDS</b>	
	NAME	TELEPHONE NUMBER ( )
	ADDRESS (STREET, CITY, STATE, ZIP CODE)	

<b>IDENTIFYING INFORMATION</b>	
MOTHER'S OR GUARDIAN NAME	HOME TELEPHONE NUMBER ( )
ADDRESS CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.)	CELL PHONE NUMBER (OPTIONAL) ( )
EMPLOYED BY (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO
ADDRESS (STREET, CITY, STATE, ZIP CODE..)	BUSINESS TELEPHONE NUMBER ( )
FATHER'S OR GUARDIAN'S NAME	HOME TELEPHONE NUMBER ( )
ADDRESS CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.)	CELL PHONE NUMBER (OPTIONAL) ( )
EMPLOYED BY (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO
ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )

<b>EMERGENCY CONTACT(S) (ONE REQUIRED)</b>	
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	RELATIONSHIP

<b>OPTIONAL</b>	NAME	TELEPHONE NUMBER ( )
	ADDRESS (STREET, CITY, STATE, ZIP CODE)	RELATIONSHIP

<b>PERSONS AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY (ONE REQUIRED)</b>	
NAME	NAME

<b>COMMENTS ON CHILD'S DEVELOPMENT</b>	
(NOTE ALLERGIES, HABITS, SPECIAL LANGUAGE, ETC.)	

<b>TO BE COMPLETED BY CHILD CARE FACILITY (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)</b>	
FACILITY NAME	ADMISSION DATE
ENROLLED FOR (DAYS OF THE WEEK)	FULL TIME/PART TIME
HOURS PER DAY FROM TO	
DISCHARGE DATE	

CHILD'S NAME

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize

\_\_\_\_\_  
PROVIDER/LICENSEE

to contact the following:

**PHYSICIAN OR CLINIC**  
(Please list name and phone number of physician and/or clinic.)

NAME

TELEPHONE

(    )

ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL

**PREFERRED HOSPITAL**  
(Please list name and phone number of hospital.)

NAME

TELEPHONE

(    )

ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL

**TRANSPORTATION TO AND FROM SCHOOL**

I  (DO)     (DO NOT) GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD TO AND FROM SCHOOL.

**FIELD TRIPS**

I UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSIONS AND THAT I WILL BE NOTIFIED WHEN THEY ARE PLANNED.

**ACKNOWLEDGEMENTS**

- A) I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.
- B) I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CHILD CARE CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.
- C) THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR AND INDIVIDUAL NEEDS.
- D) WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.

**PARENT/LEGAL GUARDIAN SIGNATURE**

**DATE**

